DOCUMENT RESUME

ED 330 161 EC 300 133

AUTHOR Woeppel, Patrice
TITLE Facilitating Social Skills Development in Learning Disabled and/or Attention Deficit Disordered Second to Fifth Grade Children and Parents.
PUB DATE 10 Oct 90
NOTE 70p.; Ed.D. Practicum, Nova University.
PUB TYPE Dissertations/Theses - Practicum Papers (043)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Aggression; *Attention Deficit Disorders; Behavior Change; *Behavior Problems; Elementary Education; Games; Group Discussion; Interpersonal Competence; *Learning Disabilities; Parent Attitudes; *Parent Education; Parent Participation; *Problem Solving; Program Effectiveness; Role Playing; Sex Differences; Social Support Groups; Teaching Methods
IDENTIFIERS Rochester Social Problem Solving Skills Program

ABSTRACT

The project attempted to improve the social problem solving skills of second to fifth grade children with learning disabilities and/or attention deficit disorders, and to offer support to their parents and improve parenting self-confidence. Both the parent group (N=9) and the children's group (N=5) used the Rochester Social Problem Solving Skills Program. Parents were trained in eight bi-weekly sessions in how to use the program at home with their child. A portion of each parent session was designed to provide parents with a support group. Children met for eight weekly sessions. A variety of games, role plays, and other activities were used to teach children the six-step Social Problem Solving Skills model. The Achenbach Child Behavior Checklist was administered pre- and post-program implementation. Both internalizing and externalizing behaviors decreased in 67% of the children of the parents' group. At least one social competence scale indicator increased for each child post-tested in the children's group. Some negative changes were noted as well. Girls showed greater reductions than boys in internalizing and externalizing behaviors, particularly in aggressive behaviors. Overall, greater gains were noted in the children of the parents' group than in the children participants' group. Parents attributed the most importance to the support portion of the group. (39 references) (Author/DB)

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ED330161

Facilitating Social Skills Development in Learning Disabled and/or Attention Deficit Disordered Second to Fifth Grade Children and Parents

by

Patrice Woeppel

Cluster 28

A Practicum II Report Presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1990

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier: Stephen Bauer, M.D. Stephen Bauer M.D.

Developmental Pediatrician
Title

The Developmental Unit
Address The Genesee Hospital
224 Alexander St
Rochester NY 14607

September 10, 1990

This practicum report was submitted by Patrice Woeppel under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

October 10, 1990
Date

Polly Peterson, Ph.D.
Polly Peterson, Ph.D.

ACKNOWLEDGMENTS

Special thanks to Linda Schrier, for her expertise and assistance in co-leading the Children's Group, Steve Bauer, M.D. for reviewing materials throughout this practicum, Polly Peterson, Ph.D., Linda Crawford and Mickey Toker for their support and encouragement, Park Ridge Hospital for providing space for the Children's Group, Emmanuel Baptist Church for providing space for the Parents' Group, all the parents and kids who participated, my family and friends who accepted my long hiatuses between calls and visits, and especially to my son Jamal who teaches me so much.

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ABSTRACT

Facilitating Social Skills Development in Learning Disabled and/or Attention Deficit Disordered Second to Fifth Grade Children and Parents. Woeppel, Patrice, 1990: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood.
Descriptors: Attention Deficit Disorder/Attention Deficit Disorder with Hyperactivity/Learning Disabled/Learning Disabilities/Parents/Parent Involvement/Parent Facilitator/ Social Skills/Problem Solving Skills/Problem Solving Curricula(um)/self-esteem.

Learning Disabled (LD) and attention deficit disordered (ADD) children often lack the social problem solving skills and component skills appropriate to their age. The goal of the project was to improve the social problem solving skills of a small number (20) of LD/ADD second to fifth grade children, to offer support to parents and improve parenting self-confidence.

Parents of identified learning disabled (LD) and/or attention deficit disordered (ADD) children were invited to participate in a parent group and/or to have their children participate in a children's group. Both groups used the Rochester Social Problem Solving Skills (SPS) Program (Weissberg R., Gesten E., 1980). Parents received an eight (8) session bi-weekly training in how to use the program at home with their LD/ADD child. Half of each parent session was a support group. Children met for eight (8) weekly sessions. Using a variety of games, role plays, and other activities, children were taught how to use the six-step SPS model.

The total project implementation spanned one year. The Achenbach Child Behavior Checklist was administered pre- and post. Both internalizing and externalizing behaviors decreased in 67% of the children of the parents' group. At least one social competence scale indicator increased for each child in the Children's Group post tested. Some negative changes (increases on behavior problem scales or decreases in social competence scales) were noted as well. Girls showed the greater reductions in internalizing and externalizing behaviors, particularly in aggressive behaviors. Overall, greater gains were noted in the children of the Parents' Group. Parents attributed more importance to the support portion of the group.

CHAPTER I

INTRODUCTION

Description of Community/Program Setting

A group of about 120 parents of learning disabled (LD) and/or attention deficit disordered (ADD) children from a mid-sized city in western New York State and its suburbs formed an independent group, leaving behind its original sponsor, a local chapter of the Association for the Learning Disabled. This group had been meeting once a month for over a year. Most of the parents were middle class parents from the suburbs surrounding the city.

Employment in the area is heavily executive, technical manufacturing and export. The unemployment rate is low. Perhaps because of the presence of two major multinational companies in a small city (pop. 240,000), there is a heavy emphasis on education and educational improvement, particularly as it relates to preparation for the technological skilled employment needs in the area. The city has four major colleges and one university within its borders, and several more in surrounding communities.

Writer's Role

The writer has worked in an administrative and program

development capacity in children's services for twelve years and has presented at workshops and conferences on the subject of learning disabilities and attention deficit disorder.

The writer's prior experience includes monitoring and evaluation of a county-wide system of children's mental health services. In this capacity, a review of case records revealed that many parents of LD/ADD children sought help for their child's problems and support for themselves at several clinics one after another, leaving each after a brief period to try once again somewhere else.

The writer is also the mother of a learning disabled child who has a history of attention deficit disorder.

CHAPTER II

STUDY OF PROBLEM

Description of Problem

Learning disabled and attention deficit disordered children often lack social skills. Additionally, their social skills do not appear to improve measurably with age (Dickstein and Warren, 1980).

Social skills development of LD and ADD children has received attention in the literature with successes as well as failures noted.

Although the teaching of social and social problem solving skills in schools has increased, the routine, systematic teaching of these important skills has not generally been institutionalized.

Parents of LD/ADD children often find their time compromised between family, work responsibilities, and the special needs of their LD/ADD child or children. Parents often continuously interact with one or more systems in their efforts on behalf of their LD/ADD child(ren).

Mental health clinicians have as their focus the emotional well-being of the child and/or the parent. The specific teaching of social skills is not generally part of therapeutic skills repertoire.

The child is often presumed to be learning (social skills) by doing. But life goes on for the LD/ADD child and whatever social skills (s)he has or does not have are put to the test each day with peers, siblings, teachers, parents.

Social skills are recognized as an important part of healthy functioning (Weissberg, Gesten, et al, 1980). Conversely, the lack of social skills is identified with those adults exhibiting mental health problems (Cowen, et al, 1973).

LD/ADD children often do not develop social skills appropriate to their age. Neither school, clinic nor parent has generally and routinely taught social problem solving skills to LD/ADD children. Because these skills are so important for healthy functioning throughout life, these skills need to be taught.

Documentation of the Problem

That the LD/ADD child lacks in social skills in comparison to his/her non-handicapped peers has been well documented in the literature.

Carlson (1987) reports that the social goals of LD children are deficient. LD children attempt to resolve conflict at the behavioral extremes rather than through negotiation or compromise.

What is more difficult to substantiate through the literature is that a gap in services exists for LD/ADD children. That gap is assistance in the development of age

appropriate social skills. It is the parents who perceive the gap most strongly, who live with it every day, year into year.

In 1981, the New York State Association for the Learning Disabled surveyed parents of learning disabled children throughout New York State. Over 650 parents responded. The survey identified "social and behavior judgment" as an unmet need for fully 58% of the 6-15 year olds represented by the parent respondents.

In the two-county area including this city and its surrounding suburban and rural areas, 858 children with the DMS-III R Code 314.0 attention-deficit disorder with hyperactivity diagnosis were enrolled in mental health services in the 23 months between 1/1/88 and 11/30/89. Over seventy-eight percent (78.4%), or 673 children, were in the 5 to 12 year age range. (Data from Integrated Mental Health, Inc., Rochester, New York.)

Since last fall, on the first Wednesday of every month, about 120 parents have met at a community center in the heart of this city in Western New York. Some came because they thought their child might be learning disabled (LD) or attention deficit disordered (ADD) and they wanted to learn more. Most came because they knew and were eager to learn as much as they could about the disorder that affected their child as well as themselves, and because they sought support from others who understand.

Often parents spoke of their stress and exhaustion, or of conflict between the parents as to how to deal with their child's behaviors.

The Diagnostic and Statistical Manual, third edition revised (DSM-III-R, 1987) defines undifferentiated attention deficit disorder as a persistence of "developmentally inappropriate and marked inattention" that is not symptomatic of any of a number of other identified disorders.

The New York State Education Department, Regulations of the Commissioner, (8 NYCCR Part 200.1 (CC) (3)) define learning disabled as a "disorder in one or more of the basic processes involved in understanding or in using language, spoken or written, which manifests itself in an imperfect ability to listen, think, speak, read, write, or spell, or to do mathematical calculations" which are not "primarily the result of visual, hearing or motor handicaps, of mental retardation, of emotional disturbances, or of environmental, cultural or economic disadvantage."

This practicum will use these two definitions throughout.

Part 200.1, however, continues its definition of the learning disabled child as one who "exhibits a discrepancy of 50 percent or more between expected achievement and actual achievement determined on an individual basis," (8 NYCCR Part 200.1 (CC) (3)). Additionally, the school district

does not recognize a diagnosis of ADD. Thus, there were no data from this source to document the ADD, and only the more severe cases meet the 50% discrepancy criteria for identified LD. In January 1988, there were 71 elementary school youngsters in the city school district meeting the state's criteria for LD as identified above.

In one local private school that serves exclusively the LD/ADD child there were 43 students in grades 4 through 12 last year.

While some LD children also have ADD, some do not. The one thing many share is the limited repertoire of social behaviors: they lack the manifest social skills expected of children their age (Dickstein and Warren, 1980; Oliva and LaGreca, 1987).

Analysis of Causes

The literature on social skills acquisition of LD and/or LD/ADD children, in comparison to their peers, supplied a variety of possible causes for their lack of social skills.

Gresham (1982) identified three components of social skills deficits: lack of knowledge, performance deficiencies, and the inability to control impulses.

Other authors noted the lower preception of self-esteem among LD children in comparison to their peers (Waldron, et al, 1987).

It has been posited that LD children lack the knowledge

of appropriate behaviors (Pearl and Bryan, 1982), or that LD children lack the cognitive skills to comprehend what is required of them socially (Oliva and LaGreca, 1987), or that problems are compounded because of the repeated negative interactions between them and their non-handicapped peers (Gresham, 1982). Finally, some authors see an environmental admixture which includes regular classroom teachers as well as peers' negative perceptions of the mainstreamed handicapped child as contributing to the poor social skills of the handicapped child (Cartledge, Frew, and Zaharias, 1985).

Some authors report deficient role-taking skills of LD children compared to their peers (Bruck, 1982; Dickstein and Warren, 1980).

Social skills development may be the result of moving through a series of developmental stages and/or the result of environmental interaction, enmeshing and synchrony (Bandura, cited in Gresham, 1982).

In sum, both LD and ADD diagnoses contain neurological and/or cognitive and/or perceptual dimensions. Any one or all of these dimensions can impact on the child's social skills. The presence of any neuropsychological impairment in a child disrupts ego development (Rothstein, et al, 1988) and thus lends itself to behavorial disturbance as well.

Relationship of the Problem to the Literature

In a study of the effects of social skills training on

underachievers, disruptive children and exceptional children vs. controls, Rotheran (1982) found that the social skills groups improved in assertiveness, teacher and peer perception, social competence and in grades. However, each group improved most in its area of strength, least in the area of weakness. Findings held up at one year follow-up with preliminary indications of overlap of the areas strengthened into other skill areas as well.

The work of Waldron, et al (1987) pointed up the differences in learning disabled gifted between those identified as LD because of hyperactive behavior and those not identified by the teacher (no hyperactive behavior). LD gifted were found to be less disruptive than their non-LD peers in the regular classroom, although less social. On the Piers-Harris, the LD gifted rated themselves lower than their peers on all six indicators, with the largest difference that LD gifted rated themselves less smart compared to their peers.

Thus, this study indicated that there are categories within LD that must be recognized, e.g., LD with hyperactivity vs. LD without hyperactivity, and that while the hyperactivity is readily recognized, LD children that are not hyperactive may not be getting the help they need, with possible detrimental impact on their self-concept.

Carlson (1987) also identified a small subsample of LD children who were more adept socially than their LD or non-

handicapped peers. The author also noted that situations involving conflict posed the greatest challenge to the LD's social skills. In conflict situations, LD children's goals tend to be aggressive or passive, rather than seeking negotiation or compromise, a win-win approach. Thus the author recommends a concentration on goals in any social skills program for LDs.

Children with hyperactivity, LD and/or ADD, are at risk for depression (Spoto, 1987).

In a small study involving three LD children the improvement in social skills evident in the role play did not generalize to the natural environment and did not change ratings on sociometric tests (Berler et al., 1982). The authors did not state whether the four content areas of the training occur in the order of least threatening (easiest) first. Based on subsequent work on social skills training (Carlson, 1987), areas involving conflict would be expected to be the most difficult for LD children to master and to generalize. Thus to build on success, the conflict situation content should be taught last.

Dickstein and Warren (1980) found a significant difference in the cognitive, affective, and perceptual role taking abilities of LD children vs. their non-handicapped peers, with the LD children scoring much lower. The performance of both groups improved with age. The 10-year old LD performed only slightly better than the 8-year old

LD, while the 8-year old normals attained near perfect scores.

Bruck and Hebert (1982) also studied the cognitive and affective role taking skills of LD children. The results were comparable to those of Dickstein and Warren. However, the authors found that while the sample was too small to be conclusive, their data indicated that poor social skills may be related to the hyperactivity rather than the LD. Additionally, LD girls were rated lower than LD boys on parent ratings which is an area of concern.

Using both measures of social desirability and self-esteem, Pearl and Bryan (1982) compared LD and non-LD children in two school districts. In one district, LD children scored higher than their peers on their self-ratings of social desirability behaviors. On the self-esteem measure, LD girls had lower scores than LD boys in one school district only. The results suggest that environment influences perceptions of self-esteem.

The authors proposed that the results on the social desirability scale indicated that LD children desire to behave like other children, despite their differences in actual performance. Thus, other factors must be explored to explain the difference.

Cartledge, Frew, and Zaharias (1985) studied the behaviors that peers deem important for acceptance and the behaviors that teachers valued in LD mainstreamed children.

LD children were perceived as kinder by their non-handicapped peers. However, communication skills and play/sport skills appeared to be the factors predictive of peer acceptance.

Teachers, however, gave the lowest ratings to the very skills ranked highest in importance by peers. The authors suggest that teachers need to help students acquire these skills. The likelihood of this is slim however, given the teachers' value system which ranks these skills of far lesser importance to task-related behaviors in an already demanding classroom environment.

In Vaughn and Lancelotta (1986), one of the two experimental groups in a social problem solving model for LD children paired an LD child with a highly regarded classmate based on sociometric measures. Both experimental groups made significant gains on one dimension of problem solving, i.e., number of non-violent solutions posed, although not on some others. The expected gains in peer acceptance resulting from pairing did not materialize.

Gresham and Reschly (1986) identified serious deficits in task-related behaviors among LD children, which as previously noted (Cartledge, Frew, and Zaharias, 1985), teachers rank as most important to adjustment and performance in the classroom.

Some authors focused specifically on interventions with parents to effect change in themselves, their children

and/or the environment.

Carlucci (1987) noted the difficulties of engaging parents in a school based program for children with identified problems.

In one study, parents of a small number of subjects were engaged in the data collection process in order to assist in assessing generalization of skills prior to each child's entry into a new classroom environment (Blackbourn, 1985).

Twenty-three parent-couples of LD 4th-6th grade children were randomly assigned to an experimental group using the Parent Effectiveness Training model (Giannotti and Doyle, 1982). On post-test, parents in the experimental group reported increased self-confidence in their parenting, increased acceptance, understanding and trust of their children and increased awareness of how their behavior effects their children over controls.

In a study of ten LD children and their parents, relaxation training improved attention span in the children and improved parenting behaviors in the parents. It is not noted whether these gains were maintained over time (Omizo, et al, 1982).

An eight session combined information and support group for parents of LD children was used to improve a school's retention of its LD children (Akins, 1988). The project demonstrated improved understanding of LD by both parents

and teachers.

Family therapy was seen as an important supplement to medication and educational planning in improving self-esteem, self-control, and frustation tolerance in the child. However, the focus of the therapy was both the child's development and the family organization (Ziegler and Holden, 1988).

The author posits that in healthy families the work with the parents should focus on limit setting and structure. Therapy with the child is task specific, while improving functioning in the three areas identified earlier. The work described is anecdotal, based on individual cases in a hospital-based program.

A classroom behavior management model using tokens with one child demonstrated significant improvement in on-task behaviors, reduced off-task, inappropriate gross motor behaviors and vocalizations in the classroom when the program was combined with medication (Wells, 1986). Wells also summarized the literature on parent training using behavior management techniques, i.e., positive and cost contingencies.

Forty-six (46) families of hyperactive ADD pre-schoolers were given a parent training intervention (Pisterman, et al, 1989). In ten group sessions, parents were taught to decrease directive behaviors, reinforce positive behaviors, issue appropriate commands and use time-

outs. In the treatment group, positive behavior interactions increased, directive behaviors decreased over controls, while controls remained stable. Generalization of the treatment effect from the clinic to the home was not assessed.

Breen and Barkley (1988) examined both degree of psychopathology and parenting stress in attention deficit disorder with hyperactivity (ADD-H) girls compared to ADD-H boys, normal girls and clinic referred non-ADD-H girls based on a sample of thirteen children in each of the four groups. ADD-H girls were found to be more hyperactive and more depressed than ADD-H boys, but similar to clinic referred non-ADD-H girls. Parenting stress was essentially the same for both ADD boys and girls and clinic referred non-ADD girls. Based on the correlational analyses of the fifteen Parenting Stress Index scales, the authors concluded that parenting stress is a feature of parents of children evidencing psychopathology, particularly with aggressive or hyperactive features.

In a small study of trained parent-child dyads, Guevremont, Tishelman and Hull (1985) trained two ADD-H boys and the parent of each to administer a self-instruction program to the boys at home using a token system. The eight-week program utilized self-verbalization and individualized task-specific behaviors modeled by the therapist with each boy. The authors found that the use of

task-specific self-instruction resulted in demonstrable and immediate gains in school performance. There is no indication whether these gains were maintained over time. The sample is also quite small.

Coping and defense mechanisms were investigated in 24 mothers of LD children (Faerstein, 1986). An incidental finding of this study was that an average 3.5 year gap existed between suspicion of and confirmation of the diagnosis. While mothers seemed to cope well in obtaining services for their child(ren); in the parent-child interaction denial, projection, and anger were reported.

In a study of 91 parents, Sobol, et al (1989) found that mothers of ADD-H children perceived the causes of their child's behavior to be more unstable than mothers of non-ADD-H children. Parents of ADD-H children were found to have lower expectations of future compliance.

The author concludes that parent training would be more likely to work for those parents who see themselves as affecting outcomes in relation to their ADD child's behaviors.

Barkley (1986) finds that parents of ADD children tend to be more directive and reprimanding with their child(ren) and less praising of compliance than parents of normal children. The author recommends a ten step parent training program including training parents to attend to positive behaviors, training in home token reinforcement systems, and

time-outs.

Symbolic modeling and two phases of a parent training program were compared in their effects on non-compliant behaviors of six hyperactive children (Henry, 1987). Symbolic modeling, i.e., videotapes of same age and sex children modeling compliant behaviors in response to adult commands, was ineffective and two cases, increased non-compliance. Phase 1 of parent training taught parents how to attend, reward, ignore, and give commands. Phase 2 taught the use of time-outs which resulted in rapid and dramatic compliance in all subjects. In all four parents reporting at six month follow-up, improvement had been maintained. The author concludes that the use of time-outs is an essential component in parent training. The possible cumulative effect of the symbolic modeling and Phase 1 behaviors is acknowledged by the author.

Self-esteem and self-perception appear to play a role in mastery of social skills as do expectations and/or negative perceptions of others. Conflict situations are the most difficult social situations for LD/ADD children to negotiate.

Several studies dealt with very small samples or were anecdotal. Generalization of the treatment effect has been identified as a concern in several studies, either from clinic to home, or from parenting group to school, etc. A few authors noted the tendency of parents of ADD children to

be more directive in the parenting interactions with their ADD child(ren).

Deficiencies have been identified in knowledge, performance, and ability to control impulses across all three significant areas in a child's life, i.e., home, school, peers. Thus, remediation should involve behaviors in all three areas.

Overall, there appears to be merit in teaching home behavior management skills and providing support to parents of LD/ADD children.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals

The goal that was projected for this practicum was to improve the social skills of second to fifth grade learning disabled (LD) and/or attention deficit disordered (ADD) children. By involving parents in the improvement of their LD and/or ADD child(ren)'s social skills, it was expected that the potential for retention and generalization of social skills would be maximized and, additionally, that parents' self-confidence in their ability to parent their LD and/or ADD child(ren) would improve.

Objectives

The following objectives were projected:

1. To demonstrate positive outcomes in identified social skill indicators for 70% of the LD and ADD children who participated in the project directly or whose parents participated in the project's Parent Social Skills Facilitation and Support Group, as measured by parent report on the Achenbach Child Behavior Checklist post-test following the end of the involvement in the project.

2. To demonstrate parent involvement in an eight (8)

session Parent Social Skills Facilitation and Support Group for parents of a minimum of fifteen (15) LD and/or ADD children.

3. To demonstrate child involvement in an eight (8) session Social Skills Group for a minimum of five (5) LD and/or ADD children.

4. To document improved perception of self-confidence of parents in their parenting of their LD and/or ADD child(ren) by at least an increase of 10% on a 1-10 scale pre and post self-report measure in at least 80% of the participant families.

Mechanism for Recording Unexpected Events

A journal was kept throughout the implementation process. The journal was used to record anecdotal information; questions; issues; observations; identification of areas for exploration; unexpected patterns, behaviors, or results; serendipitous effects and changes in the actual implementation from the planned implementation.

Evaluation and Evaluation Instruments

Each parent and set of parents wishing to participate in the Parent Social Skills Facilitation and Support Group or for their child(ren) to participate in the Social Skills Group was contacted by the writer either by telephone or in person. Parents were encouraged to share information about their child and their interest in the group. The group was

explained and parents were asked to fill out the Achenbach Revised Child Behavior Checklist for Boys 6-11 or Girls 6-11 years, whichever was appropriate. The writer planned to meet with the parent(s) of multiple learning disabled and/or attention deficit disordered children to facilitate the Checklist process and also to obtain anecdotal information.

The Achenbach Child Behavior Checklist has been developed using a fifth grade reading comprehension level. The Checklist provided a base measure on social competence, internalizing and externalizing behaviors for each child. The Achenbach in a 118 item Likert scale instrument that measures social competence, internalizing and externalizing behaviors in 4-16 year old boys and girls. The instrument has demonstrated significant content validity in all three areas, specifically on 116 out of 118 items (the two exceptions are health related, i.e., allergy and asthma items). Thus, the Achenbach has been able to effectively distinquish children needing mental health services from those who do not (Achenbach, 1983).

It was anticipated that improvement in social skills should increase prosocial activities and reduce hyperactive and/or aggressive behaviors, the latter because of the expanded repertoire of the child's social problem solving skills and choices. The Achenbach was chosen because it contains all these measures and has been well standardized over the years with demonstrated high test-retest

reliability on a variety of measures (Achenbach, 1983). Furthermore, two of the behavior problem scales plus the social competence scales related specifically to the behaviors of the target group and the focus of this practicum.

Parents were also requested to provide either diagnostic information or to give permission for the writer to secure diagnostic information on their child. Thus the diagnosis of LD and/or ADD was established for each child participating directly or indirectly in the practicum project. It was hoped that such diagnostic information would also provide specific information on areas of perceptual strength as well as weakness so that the group sessions could modify the materials to accommodate specific ways that each child would best input new information and respond to the environment.

Following the end of the Parent Social Skills Facilitation and Support Group, it was planned that the parents would meet again with the writer and be interviewed as well as complete the Achenbach Revised Child Behavior Checklist for Boys 6-11 years or Girls 6-11 years.

The Parent Social Skills Facilitation and Support Group was projected to contain a minimum of ten (10) parents of fifteen (15) LD and/or ADD children. If two parents of the same child were in the group, an additional parent would be accepted to a maximum of twenty (20) parents in the group.

Attendance was recorded at each group session.

A minimum of five (5) and a maximum of eight (8) LD and/or ADD children were projected to participate in the eight (8) session Social Skills Group. Attendance was recorded at each group session.

At the last group session, each parent was asked to anonymously fill out an evaluation that included a self-report on parenting confidence and change in parenting confidence. An increase of 10% on the 1-10 scale measure of perception of self-confidence was expected for a minimum of 80% of the parent participants and parents of the child participants. The measure was two questions adapted with permission from the EPIC Final Workshop Evaluation for Participants (National Effective Parenting for Infants and Children, Inc., Buffalo, New York): "How confident did you feel as a parent of your LD/ADD child(ren) before you started the workshop?" And, "how confident..... now." Responses were scored on a 1 to 10, low to high scale.

This measure was included on the premise that parents who increased self-confidence might also increase their expectations of and/or actual compliance in their child's behaviors.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

Appropriate social skills are necessary for normal healthy functioning in society. The questions are how to teach, what to teach, and to whom in order to effect appropriate social skills and behaviors in LD/ADD children.

The life of an elementary school child is composed of three basic influences: home, school and peers. To impart social skills directly in the peer setting can be attempted. However, social skills are required in many areas, not just with peers.

As the literature has indicated, teachers often place the highest value on task behaviors (Cartledge, Frew, and Zaharias, 1985) while the social skills deficits identified for LD and ADD children are much broader (Gresham, 1982).

The repetition and rehearsal necessary for retention of skills works best over a long period of time (Tableman, cited in Aronowitz, (Ed.), 1982). Home is generally the most constant of the three environments in the life of the child and thus may be the optimal setting for repetition and rehearsal of the learning.

Amerikaner and Summerlin (1982) successfully used

relaxation techniques to reduce acting out behaviors in LD children. Their study of LD children found that those in social skills training had better self-concepts, in the social sphere only.

Camp and Bash (1981) identify verbal mediation deficits in early elementary aged aggresive children and demonstrated increased social skills as well as reduced aggression in the treatment group receiving a social problem solving program with heavy emphasis on self-directed speech.

Gresham (1982), cited previously, identified three components of social skills deficiencies: lack of knowledge, performance deficiencies, and the inability to control impulses. Each of these deficits would be remedied differently.

Deficits in the first and last category would lend themselves well to a psycho-educational social problem solving model. In the case of the latter, one such model builds in a strategy for reminding children to inhibit impulses before they act, that is the Rochester Social Problem Solving Skills model (Weissberg et al., 1980).

Performance deficiencies would benefit from a program and setting that reinforces the desired social behaviors (Gresham, 1982).

The work of Cartledge et al, (1986) indicates no direct relationship between social skills and social perception and concludes that social skills training is more likely to

affect social behaviors than attempting to change perceptions.

Findings of Oliva and LaGreca (1987), cited previously, indicate that LD children may lack both social knowledge and behavioral objectives appropriate to their age.

These findings seem to support a psycho-educational social problem solving model that would focus on both objectives and strategies for action as well as behavioral rehearsal.

In the treatment of long-term physical illness, the importance of involving the patient in the adaptation process, including empowerment of the patient, patient participation in the planning process, and an emphasis on coping for family and patient has been recognized (Mailick, cited in Aronowitz and Bromberg, (Ed.), 1984). With LD and ADD children, often the focus has been compartmentalized to educational remediation and amelioration of emotional symptoms respectively. Working with parents refocuses on coping and provides both parents and child with a new set of tools for adaptation.

Much attention is being given today to the role of the parent as a child's primary teacher. Often the parent of the LD/ADD child has tried everything in his (her) parenting repertoire. An overwhelmed or stressed parent is less able to effectively set limits, thus increasing the insecurity of a hyperactive or ADD child (Woeppel, unpublished, 1983).

Assisting the parent to become the teacher of the child's social skills can empower the parent as well as empowering the child.

The solution selected was a social skills training model incorporating verbal mediation and self-directed speech, presenting children with an expanded knowledge of social behaviors and assistance in controlling impulses, and their parents with an additional management tool. Repetition and rehearsal of the desired behaviors were facilitated by directing one part of the program to parents.

Description of Solution Implemented

The thirty-three lesson Rochester Social Problem Solving Program (SPS) formed the core of the practicum intervention described herein. The SPS was selected because it incorporated many of the elements associated with success described in the literature.

Parents of diagnosed LD and/or ADD children in second through fifth grades in the local community who had been meeting once per month for the past year, were the primary recruitment source for the participants in both the parent's and children's groups implemented as part of this practicum.

Of the 120 parents in this group thirty (30) parents expressed interest. Upon telephone follow-up, eleven (11) agreed and nine (9) started the group. These nine were parents of thirteen (13) LD/ADD children. All nine (9) stayed through completion.

It was planned to recruit parents of LD and/or ADD children receiving services at a local hospital-based developmental center. Many of the parent participants were known to the developmental center although recruited through the primary source. Additionally, a local allergist became a recruitment source for the children's group. Here, too, parents recruited were also involved or became involved with the primary recruitment source, the association of parents of ADD children mentioned in Chapter II.

One parent group and one children's group were implemented as part of this practicum.

Parents expressing interest in either group were telephoned so that they had an opportunity to ask any questions, share information about their child, and to receive additional information about the goals and content for the groups, and the expectations for group members. The expectations upon the parents were that parents agree to fill out the pre-post test instrument, provide diagnostic material, attend or bring their children to all eight sessions, purchase the Rochester Social Problem Solving Skills manual (Parents' Group only), and use the new skills at home between each group session.

The writer had intended to interview all parents of multiple LD/ADD children at their homes. This was done with two (2) sets of parents for six (6) children. With the first family it was a general exploratory meeting. With the

second family, given the workload of both parents and the special and unique needs of each child, the aim was to make it easier to fill out the Achenbachs by doing it together. This did not work out. Only the mother and the children were home and any attempts to discuss the children raised the anxiety of the oldest child. However, meeting all the children in the family was helpful later in the Parents' Group discussions.

The first phase of the implementation was expected to span approximately two (2) months. In fact, this process took three (3) months initially and an additional two (2) months prior to the start-up of the children's group.

In the second phase of implementation, parent group sessions were held once every two (2) weeks over four (4) months for a total of eight (8) sessions. Each session was one and one-half hours divided into two equal segments. The frequency of group sessions was explored with potential participants and the feeling was very strong that once weekly sessions would be too frequent. At the same time, the writer was cautioned by the parents that the number of months that the sessions could span should not be too extensive because of prior commitments surrounding the school calendar.

The first half of each parent group session was devoted to the presentation of social problem solving skills, using primarily the Rochester Social Problem Solving Skills (SPS)

Program: A Training Manual for Teachers of 2nd-4th Grade Children (Weissberg et al, 1980). The SPS program was selected because it addresses all three (3) components of social skill deficits identified by Gresham (1982) and noted earlier in this chapter.

Each parent or set of parents purchased the manual prior to the first group session so that they could use it at home, and if they desired to go through each lesson in greater detail than would be covered in the group. While the manual was designed for use in the classroom, in the parent group material was adapted for use in one-to-one. The manual gives detailed and specific dialogue to use with the child, thus facilitating the parents' ability to use the techniques being taught.

The didactic segment of group sessions also used techniques and methods developed by others as well as drawing on the experience of the parents in the group. Behavioral management tools such as charting and rewards, contracts, time-outs and do-overs were presented and discussed.

Topics presented were intended to be taught to the skills level so that the activities demonstrated, role played and/or discussed could be used at home with the LD/ADD child and with siblings as well. In fact, sometimes the role plays took the group on to related topics that the group wanted to explore. The writer chose to follow the

group's lead. Thus the material was sometimes not presented in the depth intended.

Review at each session provided a forum for feedback on the previous session's topic and its implementation in the home. Some topics were tried at home and eagerly discussed, e.g., feelings exercises, contracting, reward/token systems, generation of alternative solutions. Some topics, such as goals or "how you want things to end up," were rejected by both groups. The children had difficulty with the difference between the goal and solutions step, a not unanticipated difficulty.

Parents felt this step did not fit the typical at home parent-child conflicts. As demonstrated in the role-plays, often a parent had one goal, while the child had another. Thus the parent was not able to coach the child in problem solving to reach the child's goal. Parents felt that a "negotiation" type approach was more useful than an attempt to force a unified goal.

The second half of each parent group session was an informal sharing of ideas and discussion of problems and issues in a supportive parent to parent exchange. The importance of maintaining confidentiality was intended to be repeated at the end of each parent group session. However, it became evident that the level of trust and sharing in the group remained high.

In general, parents expressed that they felt they got

more out of the support section of the sessions than the SPS itself. This could be attributed to the deficiencies in delivery by the writer, and/or it could be the limitation of focusing primarily on one model, and/or scaling a classroom model down to one-to-one implementation in the home or all of these.

Parents' ownership of the group was very high. One parent arranged the space, typed mailing labels, and a phone list. Most parents brought in materials and all exchanged information on what had worked for them. The information ranged from information on pending legislation to available resources, books and demonstrations of available methodologies, e.g., token systems and a two-parent unified negotiation model.

The writer also brought in books which were circulated and materials on topic areas used as hand-outs.

Parents also brought the issues they were experiencing to group and gained input and support from group members.

Group sessions, particularly role-plays, had a lot of humor, banter, and laughter. Some was targeted at their kids, perhaps a healthy venting of frustration in a safe and trusting environment.

A few of the parents in the Parents' Group thought that they themselves might be ADD. One parent felt that his own struggle with organizational skills and a "low fuse" might make it more difficult for him to parent his ADD-H children.

Parents generally arrived early for group sessions and stayed after the end to chat. Almost all parents elected to continue the support portion of the group on their own after the final session.

The amount of collective knowledge, work and energy that these parents had put into learning about ADD and working with their child(ren) was substantial and impressive.

At the last group session, a workshop evaluation form was filled out (Appendix A). Planned follow-up visits were not scheduled due to limitations on the writer's time.

The nine parents in the parent group were a more homogeneous group than expected: all were middle class; all represented intact families; all were caucasian. Six were females. The Parents' Group parents collectively had six (6) LD and/or ADD girls and six (6) LD and/or ADD boys within the target age range and one (1) ADD boy outside of the age range. The total number of children as well as number of ADD children in the household varied from one (1) to three (3). Six (6) children were represented by two (2) parents in the Parents' Group.

Parent Group sessions followed the format presented in the Parent Group Outline with two exceptions; Session 6 and Session 7 were reversed by parent request for more variety in approaches. Session 8 was a finishing up of loose ends and general discussion rather than the parent self-nurturance expected to be discussed.

Parent Group Outline*

Session 1 Warm-up

Establish group and individual goals

Identification of Feelings

Coffee break

Support and general discussion

Session 2 Review

Problem Identification

Coffee break

Support and discussion

Session 3 Review

Introduction of First Three Problem Solving Steps

1) "Say exactly what the problem is"

2) "Decide on your goal" (how you want things to end up)

3) "Stop to think before you act"

Session 4 Review

Generation of alternative solutions

Coffee break

Support and discussion

Session 5 Review

Consideration of consequences

Coffee break

Support and discussion

Session 6 Review

Integration of problem solving behavior

Coffee break

Support and discussion

Session 7 Review

Other behavioral management tools

Coffee break

Support and discussion

Session 8 Post test

Refueling for parents, e.g., structured R & R, building a support network

Coffee out at local restaurant

*Outline topics for sessions 1-6 are from Rochester Social Problem Solving Program.

Recruitment efforts and the search for space for the Children's Group became a full scale focus of the practicum for two months.

The third phase of the practicum was the Children's Group. The group met for eight (8) weekly sessions of one hour each on Saturdays extending over two (2) months, in space provided by a local hospital.

In the Children's Group, the SPS program was also used, thus directly addressing the lacks in knowledge of appropriate behaviors (Pearl and Bryan, 1982) and lacks in comprehension of what is required of the child socially (Oliva and LaGreca, 1987).

Parents were invited to have their child participate and the group was explained. Prior to acceptance into the

group, a parents' meeting was held to discuss the group content and to find out more about each child's favorite activities and strengths in order to build activities around these, as well as the SPS lesson plan. Parents wishing to support the activities at home were encouraged to do so. An Achenbach Child Behavior Checklist was received from each set of parent(s).

Following the parent meeting, a letter was sent to each child inviting him/her to join a Problem Solvers Club that would meet for eight (8) weeks. (Appendix B)

Two children in the group were children of parents in the parent group.

The Children's Group was co-led by a Master's degree candidate in Special Education who is a parent of a special needs child.

The format for this group was a half hour of SPS (presentation, role-plays, games, etc.) followed by a brief snack and an activity. Wherever possible the writer attempted to reinforce the SPS lesson through the activity in the second half hour. Because this was a Saturday morning group for children who often have problems in school, a school atmosphere was avoided.

Four nine year old boys and one 10 year old girl comprised the group. On occasion, the six year old son of the co-leader was present as well. The sole girl was reluctant to participate at first, but once in the group

seemed comfortable, although she missed several sessions. The boys tended to be louder and wilder when she was present, and more settled when she was absent.

Each session started with a reminder of the rules; listening to each other, and talking one at a time. Visual symbols were drawn on the blackboard as a reminder, often by the children.

For the feelings session, children brought old tee shirts to paint with permanent paints specifically designed for cloth. This was a favorite activity that remained a choice during the next session as well.

Wherever possible, the writer and her co-leader used examples from the moment to explain the lesson. For example, J fell off his chair but was obviously unhurt. "Falling off a chair" was identified as one kind of a problem, allowing us to move to the definition of a social problem as the kind that involves more than one person.

The Deciding on a Goal (or "how you want things to end up") was one that the children had great difficulty with throughout the program. This was a step that the Parents' Group had found problematic also. The children confused goal with the possible solutions.

The group was quite prolific in generating solutions, an important aspect of problem solving. With four (4) youngsters present, there were seven (7) solutions generated in one story and eleven (11) in another story.

The activities in the second half hour were purposefully varied; painting tee shirts, doing magic tricks, games, puzzles, kite-making, drawing.

The SPS review crossword puzzle was modified to accommodate LD members: The puzzle page was blown up large enough for all five children to work on it. Scrabble pieces were used to form the words across the top of the page. Writer, co-leader, and/or group members read each item while other members took turns choosing the already spelled scrabble word and placing it in the puzzle.

Role-plays and skits did not always work out because the kids would get into their role and find it difficult to move on. This may be a special problem with an LD/ADD group and might also be magnified by the short time frame and fast pace of this particular children's group.

The problem solving mural in the original SPS program is designed to be a whole group activity. In this group, the writer wanted to use the mural as a reminder of the SPS steps that each child could take home with him/her. This proved to be too ambitious a project. It required too much organization for two children working in pairs, even on a sample problem which had already been used and was familiar to the children. The negotiation discussion and problem solving involved in the process were positive however.

It appeared that more time was needed than the eight (8) sessions, particularly for mastery of goals and

consequences and more practice in putting it all together and generalizing to other settings.

The small talk among the children changed as the group progressed: an increase in questions about each other rather than a soliliquy about themselves and a greater tolerance of and patience with each other was evident.

Modification of the format occurred as follows: the Problem Solving Mural occurred in Session 6, Skits were done in Session 5.

Children's Group Outline

Session 1	Warm ups
	Explanation of why here
	Feelings games, activities
Session 2	Identification of feelings
	Games, activities, role plays
Session 3	Introduction of the first three problem solving steps
	Games, activities, role plays
Session 4	"Think of as many solutions as you can"
	Problems stories, role plays
Session 5	"Think ahead to what might happen next"
	"Problem solving mural"
Session 6	Put it all together
	Skit preparation, skits, role plays
Session 7	Review
	Feeling concept review

Cartoons, role plays, drawing

Session 8 Social event pre-chosen

*Outline topics from Rochester Social Problem Solving (SPS) Program

Following the end of the last group session, parents were asked to complete the Achenbach again for the post test. The workshop evaluation was not used with the parents of the children's group, nor did the writer meet individually. Discussion with parents occurred at drop-off and pick-up or over the telephone as well as during the last session fun activity while the children played computer games.

The total implementation time for all three phases was ten (10) months. Preliminary parent contacts and receipt and review of diagnostic material took four (4) months, partially overlapping with other activities. The parent group spanned four (4) months and children's group covered two (2) months. Securing space in which to run a children's group took seven (7) weeks, an unanticipated delay. Total time to completion, including analysis of data and preparation of the final report was one (1) year.

CHAPTER V

RESULTS, CONCLUSIONS, RECOMMENDATIONS AND DISSEMINATION

Results

Objective 1. To demonstrate positive outcomes in identified social skill indicators for 70% of the LD and ADD children who participated in the project directly or whose parents participated in the project's Parent Social Skills Facilitation and Support Group as measured by parent report on the Achenbach Child Behavior Checklist (CBC) post test following the end of the involvement in the project.

Six of the nine Parent Group children and all four Children's Group children (76.9%) for whom the post test results were obtained showed gains in at least one of the Social Competence measures on the CBC on post test over pre-test. Thus this objective was met.

Of the thirteen (13) children of the parents in the Parents' Group, nine post tests were obtained. One child was above the age range of the practicum, one child was re-diagnosed out of the diagnostic category, two post tests were not returned. Four of the five children in the Children's Group returned post tests.

Only one child in the sample did not have both ADD and

LD. A few children also had additional disabilities, e.g., visual impairment, Tourette's syndrome.

Objective 2. To demonstrate parent involvement in an eight (8) session Parent Social Skills Facilitation and Support Group for parents of a minimum of (15) LD and/or ADD children.

This objective was not met. All nine parents who began the group remained and completed the group sessions. However, these nine parents represented thirteen (13) LD/ADD children, of whom one (1) child was later re-diagnosed out of the category.

Objective 3. To demonstrate child involvement in an eight (8) session social skills group for a minimum of five (5) LD and/or ADD children.

This objective was met. Five children began and completed the social skills group.

Objective 4. To document improved perception of self-confidence of parents in their parenting of their LD and/or ADD children by at least an increase of 10% (1 point on a 1-10 scale) on a self-report measure in at least 80% of the participant families.

This objective was not met. In 55% of the participant families gains averaging 2.4 points (24%) were reported. The range was 1 to 4 points (10-40%) perception of improvement in parenting skills. A beginning range of 1 to 7 points shifted to an ending range of 4 to 8 points.

Among the children of the Parents' Group, there was a tendency toward a decrease in both internalizing and externalizing behaviors (see Table 1).

On the internalizing behaviors T Score, six (6) of the nine (9) children from the Parents' Group showed a decrease. Two children remained the same. One child showed an increase on the internalizing behavior T Score.

On the externalizing behavior T Scores, for the children of the Parents' Group, decreases were also noted for six (6) children. Two remained the same. The same child who had increased internalizing behaviors also showed an increase in externalizing behaviors as measured by the externalizing T Score.

As Table 1 shows, no such patterns on these scales were evident on the CBC's for the children in the Children's Group.

Because the numbers of children within each group were so small, no test of significance was performed.

Viewed from a global perspective, three times as many positive score changes (i.e., higher on social competence measures, lower on behavior problem scales) were obtained on post test among the nine Parents' Group children (45) as the four Children's Group children (15). Negative score changes (i.e., decrease in social competence scores, increases in behavior problem scores) were higher for the Children's Group (17 for the 4 children compared to 20 for the nine

TABLE: 1

CBC PRE-POST TESTS SCALES AND SUMMATIVE T SCORES FOR PARENTS' GROUP CHILDREN AND CHILDREN'S GROUP CHILDREN

			SOCIAL COMPETENCE(2)						BEHAVIOR PROBLEMS(3)											
CHILD NO	SEX	GROUP	ACTIV PRE	ACTIV POST	SOCIAL PRE	SOCIAL POST	TOTAL PRE	TOTAL POST	WITHDRAWN PRE (1)	WITHDRAWN POST (1)	INT. T PRE	INT. T POST	HYPERACTIVE PRE	HYPERACTIVE POST	AGGRESSIVE PRE	AGGRESSIVE POST	EXT. T PRE	EXT. T POST	SUM T PRE	SUM T POST
1	F	P	39	41	19	36		37	87	76	77	66	80	73	86	68	81	73	83	72
2	F	P	51	43	21	10		27	78	79	80	76	85	85	93	94	83	82	87	85
3	F	P	43	39	33	45	38	35	72	55	66	60	77	78	78	74	74	73	71	68
4	F	P	51	46	36	27		19	66	55	64	52	68	67	61	55	61	58	63	56
5	M	P	44	55	36	36	36	44	62	65	59	56	75	65	69	72	71	70	66	66
6	M	P	51	53	51	55	42	45	70	65	61	58	68	73	61	59	65	65	63	61
7	M	P	55	55	46	36	42	39	76	82	68	68	78	78	67	58	70	65	69	69
8	M	P	46	49	50	55	46	52	65	61	61	61			55	55	54	52	54	54
9	M	P	51	24	46	32	33	36	69	79	54	63	67	67	87	97	77	83	71	77
2	F	C	43	47	10	10	27	28	79	74	76	77	85	90	94	96	82	83	85	86
10	M	C	35	40	32	51	29		55	57	76	76	73	73	75	70	73	71	76	75
11	M	C	46	31	34	46	36	32	73	76	59	51	68	67	59	56	63	61	61	56
12	M	C	51	35	34	46	36	29	73	76	59	65	78	85	55	58	63	67	63	68

1. WITHDRAWN SUB-SCALE CAN ONLY BE COMPARED WITHIN SEX GROUPS
2. HIGH SCORES DESIRABLE ON SOCIAL COMPETENCE SCALES
3. LOW SCORES DESIRABLE ON BEHAVIOR PROBLEMS SCALES

Parents' Group children). (See Table 1.)

The most significant gain for the Children's Group was the increase in one or more social competence measures noted previously for every child. This was consistent with the goal of the practicum implementation. When scale means were compared for both groups, the highest gains were in one or more social competence measures, 8.8% in social competence T for Parents' Group children and 28.2% on the social scale for Children's Group children (see Tables 2 and 3).

The question remains whether the identified gains would be retained over time.

Neither age nor level of school placement nor attendance in group appeared to have an impact on the results. However, girls appeared to have made the greatest reduction in aggressive behaviors and in internalizing T, externalizing T, and Sum T scores (see Table 4).

These differences were most evident in the Parents' Group children, but can also be noted in comparison to the Children's Group boys as well, (see Table 4). There was only one girl in the Children's Group.

The withdrawn scale scores may be compared within sex groups but are not valid between sex groups because the test items on which the scale is based are different for 6-11 year old boys than for girls (Achenbach, 1983).

The hyperactivity scores stayed the same for one-third of the children. An equal number of children showed

Table 2

Pre-Post Test Means and Percent of Change For Children of Parents in Parents' Group

Social Competence Scales[1]

	Pre	Post	Gain/Loss	% Change
	X	X		
Activities	47.88	45.00	-2.88	6.1
Social	37.55	36.88	-0.67	1.8
Social Competence T	38.17	41.83	+3.66	8.8

Behavior Problem Scales[2]

	Pre	Post	Gain/Loss	% Change
	X	X		
Internalizing	65.55	62.22	-3.33	5.1
Hyperactive	74.75	73.25	-1.50	2.1
Aggressive	73.00	70.22	-2.78	3.9
Externalizing T	70.66	69.00	-1.66	2.4
Sum T	69.88	67.77	-2.11	3.1

1. High scores desirable

2. Low scores desirable

Table 3

Pre-Post Test Means and Percent Change For Children in Children's Group

Social Competence Scales[1]

	Pre	Post	Gain/Loss	% Change
	$\bar{X}$	$\bar{X}$		
Activities	43.75	38.25	-5.50	12.6
Social	27.50	38.25	+10.75	28.2
Social Competence T	32.00	29.66	-2.34	7.4

Behavior Problem Scales[2]

	Pre	Post	Gain/Loss	% Change
	$\bar{X}$	$\bar{X}$		
Internalizing T	67.50	67.25	-0.25	0.04
Hyperactive	76.00	78.75	+2.75	3.50
Aggressive	70.75	70.00	-0.75	1.10
Externalizing T	70.25	70.50	+0.25	0.04
Sum T	71.25	71.25	0.00	0.00

1. High scores desirable

2. Low scores desirable

Table 4

Means and Percent of Change in Pre-Post Test Means for Boys and Girls among Parents' Group Children and Children's Group Children

	Social Competence (2)						Behavior Problems (3)											
	Activ Pre	Activ Post	Social Pre	Social Post	Total Pre	Total Post	Withdrawn Pre (1)	Withdrawn Post (1)	Int. T Pre	Int. T Post	Hyperactive Pre	Hyperactive Post	Aggressive Pre	Aggressive Post	Ext.T Pre	Ext.T Post	Sum T Pre	Sum T Post
Girls - Parents' Group																		
Mean	46	42.25	27.25	29.50			75.75	66.25	71.75	63.50	77.50	75.75	79.50	72.75	74.75	71.50	76.00	70.25
% Change	-8.2		+7.7				-12.6		-11.5		-2.3		-8.5		-4.4		-7.6	
Girls - Children's Group (4)																		
	43	47	10	10	27	28	79	74	76	77	85	90	94	96	82	83	85	86
Boys - Parents' Group																		
Mean	49.4	47.2	45.8	42.8	39.8	43.2	68.4	70.4	60.6	61.2	72	70.75	67.8	68.2	67.4	67	64.6	65.4
% Change	-4.5		-6.6		+7.9		+2.9		+1.0		-1.8		+.6		-.6		+1.3	
Boys - Children's Group																		
Mean	44	35.33	33.33	47.66	36	30.5	67	69.66	64.66	64	73	75	63	61.33	66.33	66.33	66.66	66.33
% Change	-19.8		+30.1		-15.3		+3.9		-1.1		+2.7		-2.7				-.5	

1. Withdrawn sub-scale can only be compared within sex group
2. High scores desirable on social competence scales
3. Low scores desirable on behavior problem scales
4. Only 1 girl in Children's Group

increases as those who showed decreases in hyperactivity scores.

The reduced aggression noted in Camp and Bash's (1981) work using a social problem solving model was noted selectively in this implementation also.

Use of time-outs, contracts, rewards, and structured attending methods were incorporated into the Parents' Group, as recommended in Barkley (1986) and Henry (1987). However, there were no specific measures of any possible results.

Conclusions

The indicated gains in reduction of internalizing behaviors may be indicative of an expanded repertoire of social problem solving and more reliance on the middle ground solutions over the passive or aggressive conflict resolutions noted in Carlson's (1987) study of LD children. However, Carlson also recommended a concentration on goals in order to modulate a tendency to resolve conflicts at the extremes. This writer was unable to successfully implement this in either the Parents' or the Children's group.

Anecdotally, parents attributed more importance to the support segment of the Parents' Group than the SPS. Parents' stress is apparently an element of parenting the ADD-H child (Breen and Barkley, 1988). Did the support group reduce the parents' stress? If so, a concurrent increase in self-confidence in parenting might be expected.

This did not occur to any great degree. Possibly the low rate of improvement in parenting self-confidence is related to the low expectations of the child's compliance with behavioral objectives as noted by Sobol, et al (1989).

In order to fit within the time constraints of the practicum project, the time span from pre- to post testing for the children in the Children's Group was two to three months. This may not be sufficient time to show behavioral changes and thus mitigates against demonstrating measurable positive changes within that group.

In sum, the Parents' Group made greater overall gains than the Children's Group. Many variables could contribute to this: the Parents' Group extended over four (4) months, the Children's Group two (2) months. The Parents' Group included a support group along with the SPS program. The potential for repetition and rehearsal was greater with the Parents' Group. However, all Children's Group children increased on at least one social competence measure. It appears that even partial mastery of the social skills taught increases LD/ADD children's confidence in their own social participation and/or performance.

Recommendations

The time for the Children's Group was quite abridged, reducing a 33 lesson program to eight weekly sessions.

To be effective the topics of goal and consequences and the integration of the concepts require more time,

repetition and diversity of presentation.

Working with dyads or triads might provide less stimulation and distraction yet enough interaction to process the new skills and more quickly move to a level of trust.

The Parents' Group appears to have succeeded, however it is not clear how or why. Parents acknowledged gaining the most from the support group. The writer feels that the psycho-educational format provides a catalyst for discussion in the support group and should be retained but with a broader, more eclectic approach, as these parents identified.

Parents clearly were able to use their own experience to help others in the group and to receive help in a balanced egalitarian atmosphere.

Some follow-up at less frequent but regular intervals to facilitate retention would be desirable.

Dissemination

Upon completion of the practicum, the writer will implement this program in the city school district. The implementation will be co-led with a special education teacher in a self-contained special education classroom. It will be modified to expand the lessons, particularly in the areas of difficulty identified above.

The results of the practicum project will be presented to the area association of parents of ADD children from which the parents who participated in the Parents' Group

came. Prior to presentation to the larger group, those parents who participated will meet with the writer and informally share the results of the project. The writer has made a commitment to lead a parent support group following the completion of the practicum.

The chemical dependency treatment center at a major area hospital has expressed interest in the work because of the high correlation between ADD and alcohol abuse/fetal alcohol syndrome.

A major community mental health center in the area may explore the possibility of integrating some part of the model into its clinic as it expands into the surrounding suburban areas.

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APPENDIX A

SPS WORKSHOP EVALUATION FORM

SPS Workshop Evaluation

A. How helpful was this workshop for you? (Please circle one number)

0	1	2	3	4
not at all	not very	sometimes	moderately	very

B. Which part of the workshop was most helpful? (Choose one)

presentation ☐
group discussion ☐
of presentation
support group ☐

C. How confident did you feel as a parent of an ADD child or children before you started the workshop? (Please circle one number)

low				average					high
1	2	3	4	5	6	7	8	9	10

D. How confident do you feel as a parent of an ADD child or children now? (Please circle one number)

low				average					high
1	2	3	4	5	6	7	8	9	10

E. Is there anything you would want to see added or changed for this workshop in the future?

No ☐
Yes ☐ If yes, _____

_____

_____

_____

Other - comments:

* Items C and D have been adapted from the EPIC Final Workshop Evaluation for Participants, with permission of National EPIC Inc. (Effective Parenting Information for Children).

2/26/90

APPENDIX B

LETTER TO CHILDREN

Dear

WELCOME to the Problem Solvers Club!

Our first meeting will be

SATURDAY, APRIL 28th at 10:00 A.M.

at PARK RIDGE.

And then we will meet for 7 more Saturdays.

This Saturday, please bring an old tee shirt that you can paint. Ask Mom or Dad to help you choose one.

The enclosed directions and schedule are for Mom or Dad.

See you Saturday.

Pat Woeppel

and

Linda Schrier